STATE OF INDIANA
EMT-INTERMEDIATE CONTINUING EDUCATION REPORT

Public Safety I.D.	**Indiana Public Safety Identification Number** **Affiliation**	
Last Name	First Name	Mid. Init.
Mailing Address		
City	State Zip + 4	
Email	Home telephone ( )	

VIOLATION STATEMENT

YES ☐ NO ☐ Have you ever been charged or convicted of a crime other than a minor traffic violation?

If you answered "yes" , you must attach official documentation that fully describes the Offense, current status, and disposition of the case.

EMS MEDICAL DIRECTOR SIGNATURE

As the Emergency Medical Director, I do hereby affix my signature attesting to the continued competence in all skills outlined in Section III of this document.

Signature of Physician	Date	
Printed Name of Physician	License number	State
Telephone number ( )		

EMS REGISTRANT SIGNATURE

I, the undersigned paramedic, hereby affirm, under the penalty for perjury, that all statements on this continuing education report are true and correct, including copies of cards, certificates, and other required documents for verification. I understand that false statements or documents may be sufficient cause for revocation by the Indiana Department of Homeland Security and Emergency Medical Services Commission. I also understand that the Indiana Department of Homeland Security and the Emergency Medical Services Commission may conduct an audit of the recertification activities listed at any time.

Signature of Intermediate	Date (mm, dd, yy)

Have you been trained in NIMS/ICS? Yes ☐ No ☐

Level of NIMS/ICS training. 100 ☐ 200 ☐ 300 ☐ 400 ☐ 700 ☐ 800 ☐ Other_____

Would you be willing to assist in a disaster? Yes ☐ No ☐

INDICATE ALL CURRENT AFFLIATIONS

Ambulance Provider Organizations

Name of Provider		**Provider Certification Number**
Street Address		City
State	Zip Code	Telephone ( )
Signature of CEO		Date
Name of Provider		Provider certification number
Street Address		City
State	Zip Code	Telephone ( )

SUPERVISING HOSPITAL

Name of Hospital

Street Address		City
State	Zip Code	Telephone ( )
Signature of EMS Coordinator		Date

Name of Hospital

Street Address		City
State	Zip Code	Telephone ( )
Signature of EMS Coordinator		

Name of Hospital

Street Address		City
State	Zip Code	Telephone ( )
Signature of EMS Coordinator		

1. If a formal EMT-Intermediate Refresher course was completed, please attach a copy of the certificate of completion.
2. If a formal EMT-Intermediate Refresher course was not completed, Section 1A must be completed in its entirety. All signatures must be original.
3. All in-services and refresher courses must be done at or approved by your Supervising Hospital.

Division I—Preparatory **Required 5 Hours**

DATE	**NO. OF HOURS**	**TOPIC**	**INSTRUCTOR'S SIGNATURE**

Division II—Airway **Required 5 Hours**

Division III—Medical			Required 12 Hours
Division IV—Trauma			**Required 8 Hours**
Division V—Special Considerations - Infants, geriatrics, OB/GYN			**Required 4 Hours**
Division VI—Operations—incident command, rescue, hazmat, crime scene, ambulance operation			**Required 2 Hours**

Section 1B: CPR Certification	Section 1C: ACLS Certification
Attach a current front copy of provider card or certification	**Attach a current front copy of provider card or certification**

CPR and ACLS certification hours may be added to the appropriate divisions in Sections 1A, II and III.

SECTION II: 36 ADDITIONAL HOURS OF CONTINUING EDUCATION

12 hours must be obtained as AUDIT & REVIEW. No more than 18 hours in any 1 topic

DATE	#OF HOURS	TOPIC	INSTRUCTOR
B. VENTILATORY MANAGEMENT			
C. CARDIAC ARREST MANAGEMENT			
D. BANDAGING AND SPLINTING			
E. IV THERAPY AND IO THERAPY			
F. SPINAL IMMOBILIZATION			
G. OB/GYNECOLOGICAL SKILLS			
H. COMMUNICATIONS / DOCUMENTATION			

1. No specific amount of time must be spent on each skill or combination thereof.
2. All skills must be directly observed by the EMS Medical Director or EMS educational staff of the Supervising Hospital, either at an in-service or in an actual clinical setting. All signatures must be original.

SECTION III: EMT—INTERMEDIATE SKILL MAINTENANCE

SKILL	DATE	INSTRUCTOR'S SIGNATURE
A. PATIENT ASSESSMENT/MANAGEMENT		
B. VENTILATORY MANAGEMENT		
C. CARDIAC ARREST MANAGEMENT		
D. BANDAGING AND SPLINTING		
E. IV THERAPY AND IO THERAPY		
F. SPINAL IMMOBILIZATION		
G. OB/GYNECOLOGICAL SKILLS		
H. COMMUNICATIONS / DOCUMENTATION		

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